

INTEGRATED  
DERMATOLOGY  
OF CLINTON

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**CONSENT FOR RELEASE OF MEDICAL RECORDS**

Patient's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**RECEIVE** Records

From: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I hereby consent and authorize you to release copies of my medical record, including current and previous medical records from other practices and hospitals, and/or clinics, which are part of my medical records. PLEASE NOTE: this authorization includes consent for the release of alcohol, drug, psychiatric and psychological information: and any information relation to pregnancy, sexually transmitted diseases, HIV testing, AIDS, and any AIDS-related syndromes. It also includes any information concerning cancer, cancer testing, and cancer results. I agree that a copy of this release shall be as valid as this original release. Please send copies of all requested information as soon as possible to the address listed below:

**SEND** Records

To: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

\_\_\_ SEND ALL OF MY MEDICAL RECORDS  
\_\_\_ SEND RECORDS FROM (DATE) \_\_\_ TO (DATE) \_\_\_  
\_\_\_ SEND MY RECORDS PERTAINING TO \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_